

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/09/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MEMORIAL HOSPITAL OF SOUTH BEND</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 N MICHIGAN ST SOUTH BEND, IN 46601</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405</p> <p>Facility Number: 005053</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey November 6-9, 2012</p> <p>Date of ISDH off site review - March 27, 2013</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the November 6-9, 2012 JCAHO Accreditation Survey Report, it has been determined that Memorial Hospital of South Bend meets the requirements for Hospital Licensure in Indiana.</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1